### IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA CHARLESTON DIVISION

FRANK KENNETH MILLER, JR.,

Plaintiff,

v.

CIVIL ACTION NO. 2:18-cv-00269 Judge: Johnston

COBRA ENTERPRISES OF UTAH, INC. d/b/a Cobra Firearms, a Utah corporation; and RK HOLDINGS LLP d/b/a RURAL KING HOLDINGS, LLP, an Illinois limited liability partnership authorized to do business in the State of West Virginia,

Defendants.

#### AFFIDAVIT OF FRANK KENNETH MILLER

#### STATE OF WEST VIRGINIA

### COUNTY OF KANAWHA, to-wit:

- I, Frank Kenneth Miller, being over the age of 18, of sound mind, and having been duly sworn, say the following is true and correct:
  - 1. I hereby certify that I have reviewed each and every medical bill attached hereto.
- 2. I hereby certify that the attached medical bills are true and complete copies of all medical bills I have incurred as of May 10, 2019, are a direct and proximate result of the injuries I suffered on June 25, 2017.
- 3. I hereby certify that the sum certain for the medical bills attached hereto totals \$139,756.29.
- 4. I hereby certify that each and every medical bill attached hereto was reasonable and necessary for the medical treatment I received as a direct proximate result of the injuries I suffered on June 25, 2017.



I hereby certify that the medical bills attached hereto represent the medical bills I 5. incurred only as it relates to the injuries I suffered on June 25, 2017, and for no other reason and/or injuries.

FURTHER, THE AFFIANT SAITH NAUGHT.

TAKEN, SUBSCRIBED and SWORN TO before me this \_\_\_\_ day of May, 2019.

My Commission Expires:

NOTARY PUBLIC OFFICIAL SEAL
Tanya R Thomas
State of West Virginia
My Commission Expires

September 04, 2022 Bucci Bailey & Javins 213 Hale Street Charleston, WV 25301

{SEAL}

Date Provider

Description

Bill Amount

	SUBTOTAL			1/18-2/11/19	11/26/18	12/13/17- 5/9/18		1	06/25-27/17		06/25/17		•	06/25-26/17							07/19/17	06/25-	06/25/17	06/25/17	
	\$ 139,756.29			MedCare Therapy Center	Dr. Darshan Dave	Boone Memorial Hospital		(	Associated Radiologists, Inc.		General Anesthesia		Charleston	WVU Physicians of								CAMC	Air Evac Lifeteam	Boone Co Ambulance	THE STATE OF THE S
				Inerapies	Office visit and nerve conduction study	Therapies	Radiology Chest PA 1 V 6/27/17 & 6/30/17	Extremity w-w/o 6/25/17	Radiology Chest PA 1 V, Lumbar Spine 2-3 V, CTA Lower	Insertion Catheter Artery	Anesthesia-Removal of Small Intestine	Resect Small Intest Singl Resec/Anas	Mobilize Splenic Flex	Part Removal Colon w Anastomosis	Trauma Outpatient Visit 7/19/17	Trauma Outpatient Visit 7/12/17	CV VAS Arterial (lower left) 6/26/17	ECG Report 6/26/17	Pathology 6/26/17	Trauma Procedure 6/25/17	Trauma Evaluation 6/25/17	Inpatient Admission 6/25-7/3/17	Transport	Transport	The second secon
The state of the s	in the state of th	THE COLUMN TWO IS NOT	1.00 to 1.00 t			\$ 13,361.00	\$ 30.00	\$ 210.00		\$ 225.00	\$ 2,040.00			\$ 7,839.00	\$ 109.00	\$ 109.00	\$ 83.00	\$ 34.00	\$ 1,170.00	\$ 2,106.00	\$ 429.00	\$ //,100.13	٠l.		© 1,004,00

TOTAL DUE \$0.00

Boone County Ambulance Authority 836 4TH AVE HUNTINGTON, WV 25701-9998

### ITEMIZED INVOICE

FRANK MILLER 9964 DANIEL BOONE PKWY Foster, WV 25081 Boone County Ambulance Authority 836 4TH AVE HUNTINGTON, WV 25701-9998 866-659-9113

TO ASSURE PROPER CREDIT, RETURN THIS PORTION WITH YOUR PAYMENT Ticket #: BQ170625-2233-BCA:1

Statement Date Patient ID AMOUNT PAID 05/09/19 863793

- DETACH HERE -

MAKE CHECKS PAYABLE TO:

**Boone County Ambulance Authority** 

BALANCE \$0.00

Date of Sei	rvice Description	Patient Name	Charge(s)	Payment(s)
Charges				
6/25/2017	ALS EMERGENCY	FRANK	\$950.00	
6/25/2017	MILEAGE	FRANK	\$54.00	
		Charge Total:	\$1,004.00	
<b>Payments</b>				
Paid By:	PALMETTO GBA WV	WO MA	NDATORY INS ADJ	(\$603.97)
Paid By:	PALMETTO GBA WV	PAYME	NT	(\$318.73)
Paid By:	MILLER, FRANK	SUB - S	UBSCRIBER COURTESY	(\$81.30)
Pald By:	MILLER, FRANK	ŚŪB - S	ÜBSCRIBER COURTESY	\$81.30
Paid By:	MILLER, FRANK	PĀŸMĒĪ	NT	(\$5.00)
Paid By:	HUNTINGTON VAMO FEE B	ASIS AJ MAN	DATORY INS ADJ	(\$5.00)
Paid By:	MILLER, FRANK	Refunds	Patients	\$5.00
Paid By:	HUNTINGTON VAMC FEE B	ASIS AJ MAN	DATORY INS ADJ	(\$76.30)
Paid By:	PALMETTO GBA WV	WO MA	NDATORY INS ADJ	\$603.97
Paid By:	HUNTINGTON VAMO FEE E	ASIS PAYMEI	NT	(\$1,004.00)
Pald By:	HUNTINGTON VAMC FEE E	ASIS AJ MAN	DATORY INS ADJ	\$76.30
Pald By:	PALMETTO GBA WV	WO MAI	NDATORY INS ADJ	\$2.28



Patient Name: Frank K. Miller

P.O. Box 106 West Plains, MO 65775

Return Service Requested

patientaccounts@amgh.us Phone: (877) 288-5340 Fax: (417) 255-2312



Date of Service: 06/25/2017

### Authorization to Bill

Signing this form will not increase patient financial responsibility; however, without your signature your insurance may not pay Air Evac EMS, Inc for the services provided to Frank K. Miller. This will leave \$31,179,16 as patient financial responsibility.

Policyholder/Insured:	Call #: 30017736420A
Assignment of Insurance Benefits; Finar with you in an effort to obtain proper reimbu benefits will assist Air Evac EMS, Inc in wor	ncial Responsibility: Air Evac EMS, Inc will work for and irsement from your insurance plan. An assignment of king with your insurance plan.
that the health insurance information I have provided keeping it updated. I will use my best efforts to assist Lauthorize Air Evac EMS. Inc to submit claims, on n	which I and/or my dependents are entitled to Air Evac EMS, Inc. I certify it is accurate as of the date set forth below and that I am responsible for with submitting insurance claims.  In and/or my dependent's behalf, for payment to Medicare, Medicaid, or any Air to the company

I authorize Air Evac EMS, Inc to submit claims, on my and/or my dependent's behalf, for payment to Medicare, Medicaid, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay Air Evac EMS, Inc directly for the services rendered to me or my dependent. To the extent that my current policy prohibits direct payment to Air Evac EMS, Inc, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Air Evac EMS, Inc upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check to me and mail it directly to Air Evac EMS, Inc.

I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to Air Evac EMS, Inc on my behalf.

I understand that I am financially responsible for the billed charges for the services provided to patient by Air Evac EMS, Inc, regardless of my insurance coverage, and in some cases may be responsible for an amount in addition to that which is paid by my insurance, such as co-pay, co-insurance, deductible and any remaining balance. I agree to immediately remit to Air Evac EMS, Inc any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Air Evac EMS, Inc.

assign all rights to such payments to Air Evac EMS, Inc.

Authorization to Release Information: Air Evac EMS, Inc may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

I authorize and direct any holder of medical information or documentation to include city, county and state accident reports about me or my dependent to release such information to Air Evac EMS, Inc, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by Air Evac EMS, Inc.

ERISA Authorization (Only Applies to Employer Sponsored Plans): ERISA is a federal law that allows a patient's Authorized Representative to handle the patient's insurance claim.

I hereby designate Air Evac EMS, Inc as my Authorized Representative under ERISA and its regulations. I hereby designate, authorize, and convey to Air Evac EMS, Inc to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have relating to such insurance policy and/or benefit plan; and (2) the right and ability to pursue any claim, right, or cause of action in connection with said insurance policy and/or benefit plan, including but not limited to any cause of action under ERISA, with respect to any healthcare expense incurred as a result of the services I or my dependent received from Air Evac EMS, Inc and, to the extent permissible under the law, to claim, such benefits, claims, or reimbursement, and any other applicable remedy, including expenses, damages, penalties or fines. To the extent that the applicable insurance policy and/or employee health care benefit plan lawfully prohibits such any of the assignments described above in this paragraph, I authorize Air Evac EMS, Inc to take the actions described in this paragraph on my behalf.

	Sign, date and return this sheet
Patient Signature:	 Date:

Representative Signature: (A representative is considered to be someone other than the patient who is responsible for the patient's medical and/or financial affairs.)

Date:



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#### DEPARTMENT OF VETERAN AFF

#### 1201 BROAD ROCK BOULEVARD

HEALTH INSURANCE GLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RICHMOND

VA

23249

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MILLER FRANK	3.PATIENT SB/RTHDATE SEX 04/24/1965; M[X] /	MILLER	FRANK							
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### DEPARTMENT OF VETERAN AFF 1201 BROAD ROCK BOULEVARD

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RICHMOND

VA

23249

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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MEDICARE MEDICAID TRICARE CHAMPVA	GROUPHEALTH RECABLK OF	HER 1. INSURED'S I.D. NUMBER								
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2.PATIENT'S NAME(LastName, First Name, Middle Initial)	<u> </u>		ame, First Name, MiddleInit(a))							
MILLER FRANK	2 PATIENT SPIRTHCIATE SEX	MILLER	FRANK							
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### DEPARTMENT OF VETERAN AFF

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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# DEPARTMENT OF VETERAN AFF

HEALTH INSURANCE CLAIM FORM

APPROVED BY NUTIONAL UNIFORM CLAIM COMMITTEE MINCO M2H2

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### DEPARTMENT OF VETERAN AFF

#### 1201 BROAD ROCK BOULEVARD

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL LIBERGRA OF AN CONNECTED INFOCES FOR 2

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Guarantor Number: Guarantor Name:

Statement Date: Current Balance Due Upon Receipt: 101311949

FRANK MILLER

08/05/17 7839.00

Thank you for selecting WVU Medicine at CAMC for your healthcare needs. Please submit payment upon receipt to "WVU Physicians of Charleston." To make payment by phone or to discuss payment arrangements, please call 1-800-314-1219.

PATIENT NAME DATE	DESCRIPTION	CHARGES/ ADJUSTMENTS	TOTAL
FRANK MILLER 6/26/2017	PART HEMOVAL COLON W ANASTOMOSIS	3,918.00	3,918.00
FRANK MILLER 6/26/2017	MOBILIZE SPLENIC FLEX		354.00
FRANK MILLER 6/26/2017	RESECT SMALL INTEST, SINGL RESEC/ANAS	3,567.00	3,567.00
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MywvuChart
Your secure control health connection

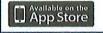
MyWVUChart is a free, easy and secure way to view your health information.

- Communicate with your healthcare providers
- Manage your appointments
- ✓ Request prescription refills
- ✓ View test results
- View and pay your bill online

Don't have a MyChart account?
Go to www.mywvuchart.com and use
the activation code below to get started



Also available on MyChart mobile





Total Account Balance \$7839.00
Insurance Pending \$0.00

#-Contested Charge \*-New Charge

Amount Due

\$7839.00

This is an attempt to collect a debt. Any information obtained will be used for that purpose.

#### PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT



PO BOX 7000 MORGANTOWN, WV 26507-7000 ADDRESS SERVICE REQUESTED

Due Date UPON RECEIPT		Guarantor # 101311949	Statement I 08/05/17	
Amount Due 7839.00	DISC VER	Card #	Exp Date	Sec Code
Amount Enclosed \$	VISA	Signature		Check #

Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

#### MAKE CHECK PAYABLE AND REMIT TO

114491-SA51-21



### Go Green Pay Online | Update Info

www.ezmedinfo.com/gas1

### Summary of Service Charges

DATE	PROC CODE	UNITS	DETAILS OF SERVICES	CHARGES	PAY/ ADJ	INSUR. PENDING	PATIENT BALANCE
Patient: FR/	NK MILLEF			Services Were F		eferred By: JOHI	
06-25-17	44120	24	REMOVAL OF SMALL INTESTINE	2040.00	1936.10	DENIAL	103.90
06-29-17			FILED PRIMARY TO VA MEDICAL CENTER OR	LANDO (VA028)	`		
07-07-17			FILED SECONDARY TO MEDICARE				
07-21-17			MEDICARE PAYMENT		139.96		
07-21-17	,		MEDICARE NON ALLOWED		1796.14		· · · · · · · · · · · · · · · · · · ·
07-21-17		-	GUARANTOR RESPONSIBILITY DATE (CHARG	GEID; 2318386)			
08-25-17	36620	1	INSERTION CATHETER ARTERY	225.00	214.48	DENIAL	10.52
06-29-17			FILED PRIMARY TO VA MEDICAL CENTER OR	LANDO (VA028)			
07-07-17			FILED SECONDARY TO MEDICARE				
07-21-17			MEDICARE PAYMENT		41.23		
07-21-17	4		MEDICARE NON ALLOWED		173.25		
07-21-17			GUARANTOR RESPONSIBILITY DATE (CHARC	GEID: 2318387)			

The insurance carrier noted above denied payment of your claim and indicated that the amount due is now your responsibility. If you have questions about your benefits or your EOB please call your insurance company. Total amount is due immediately. Please contact us to make payment arrangements.

Current	31-60 Days	61-90 Days	Over 90 Days
\$114.42	\$0.00	\$0,00	\$0.00

WE HAVE FILED YOUR INSURANCE. YOU ARE NOW RESPONSIBLE FOR THE BALANCE OF THIS ACCOUNT.

DATE DUE:	BALANCE DUE:
Upon Receipt	\$114.42

GENERAL ANESTHESIA SERVICES, INC. PO BOX 3193 INDIANAPOLIS, IN 46206-3193 1.844.898.7951

If your insurance has issued payment directly to you, please send us this payment immediately to stop the collection efforts.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

Patient Statement F	For EDAN	KMILER	 	Statement Date
rationt Statomont	OI, I KAN	LZ taur-r-iz		07/25/17
• .	•	•	•	Account Number
				497725-QGAS1

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

### ASSOCIATED RADIOLOGISTS, INC. P O BOX 11137

CHARLESTON, WV 25339-1137 TEMP-RETURN SERVICE REQUESTED

FRANK K MILLER

CI	ECK CARD USING FOR PAYMENT
MasterCarg	MASTERCARD VISA
CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT.#
09-06-17	22.88	327430-QARI1
	OLION AND	15.100

INVOICE: 2070357

PAID HERE

ADDRESSEE:

**RESPONSIBLE PARTY** 

MAKE CHECKS PAYABLE TO

FRANK K MILLER 9964 DANIEL BOONE PK FOSTER, WV 25081-6042 յիզավակիիցիհիկիինորկիանիկիրիիսով 00801

ASSOCIATED RADIOLOGISTS, INC. P O BOX 11137 CHARLESTON, WV 25339-1137 եցիլիվիոնիկներիիննիրկերկիիցիկովներիներ

To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari
Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT
PLEASE DETACH

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

For your convenience, if your personal check is dishonored or returned for NSF or uncollected funds, we will electronically debit your account for the amount of the check. A state allowable processing fee will be charged to you separately.

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09-06-2017 FRANK K MILLER 327430-QARI1 22.88

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MAKE CHECK PAYABLE TO: ASSOCIATED RADIOLOGISTS, INC.

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ASSOCIATED RADIOLOGISTS, INC. P O BOX 11137 CHARLESTON, WV 25339-1137

TEMP-RETURN SERVICE REQUESTED

CHECK CARD USING	FOR PAYMENT  VISA  VISA	
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08-02-17	17.92	327430-QARI1
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MAKE CHECKS PAYABLE TO:

INVOICE: 2056416

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RESPONSIBLE PARTY FRANK K MILLER

ADDRESSEE:

FRANK K MILLER 9964 DANIEL BOONE PK FOSTER, WV 25081-6042 միոմիիկիիկիկիկիկիկիկիկիկիկիկիկիկի

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To pay your account online, visit our website NEW WEBSITE at https://portal.ariwv.com/ari

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FOR BILLING QUESTIONS CALL (304) 344-3457

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ASSOCIATED RADIOLOGISTS, INC.

BOONE MEMORIAL HOSPITAL INC PO BOX 11407 BIRMINGHAM AL 35246-0949

#### ADDRESS SERVICE REQUESTED





003702

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#### WARANTOR NAME AND ADDRESS

MILLER FRANK K 9964 DANIEL BOONE PKWY FOSTER, WV 25081-6042 http://lipun.org

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PAYMENTS AND CHARGES RECEIVED AFTER DATE ON THIS STATEMENT WILL BE REFLECTED ON THE NEXT STATEMENT.

TO INSURE CREDIT TO YOUR ACCOUNT, PLEASE RETURN THIS STUB WITH YOUR PAYMENT.

## STATEMENT OF ACCOUNT

606144 (PC1)

PATIENT NAME	ACCOUNT NUMBER	PATIENT TYPE	SERVICE BEGIN	SERVICE END
MILLER FRANK K	523301	O/P	12/13/17	00/00/00

INSURANCE COMPANY NAME	ANTICIPATED AMOUNT	AMOUNT PAID	CLAIM STATUS
RI WEST -REC		1232.00	PAID ON 03/02/18
RI WEST -REC			INS CO R03/12/18
TRI WEST -REC	3368.00		PAYMENT PENDING
TRI WEST -REC	1736.00		PAYMENT PENDING
TRI WEST -REC	2848.00		PAYMENT PENDING

TOTAL CHARGES	INSURANCE COVERAGE	PATIENT PORTION	PAID BY PATIENT	LATE CHARGE	DUE FROM PATIENT
13361.00	9184.00	4177.00	0.00		4177.00

#### COMMENTS

YOUR INSURANCE HAS PAID. PLEASE REMIT BALANCE DUE.\*866-888-0870\* CREDIT CARDS ACCEPTED\* Visit www.bmh.org for our Financial Assistance Policy and Application

HOSPITAL NAME

**BOONE MEMORIAL HOSPITAL INC** 

RETAIN THIS COPY FOR YOUR RECORDS

8485

HIRESINGSROWSHII

37.07 - Patient Transaction Report - eClinicalWorks eBO Viewer

Page 1 of 1

## **Patient Transaction Report**

Neurology And Headache Clinic Plic

Provider:

Apr 19, 2019

Date Range: Sep 3, 2018-Apr 19, 2019

PATIENT NAME: MILLER, FRANK K		ACCOUNT #: 113	731	OOB: Apr 24, 1965
Appointment Provider Name	CLAIM NO	DATE	CODE/DESC	BALANCE
DAVE, DARSHAN	18271	Nov 26, 2018	99204 Office Visit, New Pt., Level 4	\$267.70
		Mar 22, 2019	TRICARE FOR LIFE Contractual	(\$108.25)
		Mar 22, 2019	TRICARE FOR LIFE Payment	(\$159.45)
CLAIM BALANCE				\$0.00
DAVE, DARSHAN	18277	Nov 26, 2018	95886 MUSC TEST DONE WN TEST COMP	\$330.00
		Nov 26, 2018	95913 NRV CNDJ TEST 13 STUDIES	\$755.00
		Feb 26, 2019	TRICARE Contractual	(9626.88)
		Feb 26, 2019	TRICARE Payment	(\$458.12)
CLAIM BALANCE				\$0.00
ACCOUNT SUMMARY				\$0.00
Charge				\$1,352.70
Contractual				(\$735.13)
Payment				(\$517.57)
Total Balance				\$0.00

10:17:40 AM

MedCare Therapy Center LLC 3/11/2019 9:38:11 AM Patient Ledger Visit FRANK MILLER Account #: 3407969 FRANK MILLER

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